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ABSTRACT

Having both a service mission with defined limits and an entering clientele with diverse needs has implications for the intake interview. At Kansas State University a relatively small number of clients received an inordinate amount of direct service time. Cost, effectiveness, and definition of service limits became issues to consider. The staff adapted a brief treatment model which uses a set of criteria, 9 variables called "action markers," to indicate who can best benefit from time limited treatment. However, because a gap exists between formal action marker statements and the informal ways individual staff members determined whether or not to check the markers, staff were asked to make statements about what they specifically looked for on each action marker. Putting the statements on 3x5 cards sorted by priority toward making a yes/no action marker decision proved to be useful. Staff devised a second set of action markers to monitor decisions concerning extended services. A rotating treatment decisions-team of staff members who meet regularly with the clinical coordinator to make intake decisions will be implemented to improve effectiveness. A 15.5% decrease in long-term client appointments suggests that these measures are effective. (MSF)

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Counseling Service Intakes and Brief Treatment:
From Assessment to Outcome
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University Counseling Centers typically deal with a broad spectrum of concerns as students enter the service seeking personal assistance. Presenting problems may range from situational and crisis concerns to a large number of chronic mental health problems including depression, personality disorders, and often include abuse survivors with PTSD symptoms. The intake may serve as the diagnostic assessment interview that determines suitability for service or necessity for referral, however, it also may serve as the beginning of treatment and in some cases a single session problem solving interview.

The scope of service of the counseling center mission is a factor in determining what level of student concerns could and should be treated in this setting. In this particular midwestern university such a statement was provided when the service was reorganized through a merger of counseling and mental health services. The mission statement emphasized brief treatment for developmental concerns, crisis intervention, and managed supportive care, but indicated that long-term, and specialized treatment or intensive care should be referred to outside agencies. Gilbert (1992) indicates that counseling centers must consider ethical issues involved if treatment is being provided for severe psychopathology when the mission and resources are clearly defined as brief treatment.

The combination of having a service mission with defined limits and an entering clientele with diverse needs had implications for the nature of the initial or intake interview. Contact data at the University Counseling Service during the 1990-91 academic year illustrates the range of

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client service evidenced by the number of sessions per client. It was found that 57% of clients entering the system were only seen for 1 to 3 sessions. Twenty-three percent were seen from 4-7 sessions, another 10% were seen from 8 to 16 sessions, and the final 10% seen for more than 16 sessions. Furthermore it was determined that the 10% seen for more than 16 sessions were getting more than 40% of staff direct service time. Some conclusion resulted from this data. The majority of clients were indeed being seen for "brief treatment". It was also noted that a relatively small number of clients received an inordinate amount of staff direct service time. In cost terms they could receive psychotherapy services equal to about 3 or 4 times what they had invested through tuition and fees. A further scrutiny of the longer term clients, seemed to indicate that these people fell into one of three categories; those making significant improvement, those being supported or maintained, and those that made little or no progress and were chronically recycling the same crises and concerns recorded at intake. Cost, effectiveness, and definition of service limits became issues to consider.

Four questions were discussed by the Director and staff when the agency held a service evaluation and planning retreat at the end of the 1990-91 academic year. First, would staff be prepared to acknowledge and implement a brief treatment model knowing that the majority of clients are only seen for one to seven sessions? If implemented would a brief treatment system have flexible boundaries or would if follow rigid sessions limits? Under what conditions could a client be seen over an extended period of time (for example, once a week basis during the entire year), based upon meeting some criterion of making therapeutic progress? How, could the initial session be used as an interview that could serve as assessment and screening, problem-solving or referral, preparation and treatment? The staff discussion lead to identifying several needs for understanding and making decisions about changes that could implement in the service delivery system and even more specifically during the initial interview. The first need staff identified was to become more knowledgeable about brief treatment models and processes. The second was to

find or develop an intake system that provided flexibility for making accurate and fairly immediate choices concerning treatment options and referral. A plan of staff action developed during that planning session. The first phase, taking most of that first year, was used to research and educate ourselves about brief treatment and various intake systems. A weekly aspect of staff development included in-services that reviewed readings, and provided presentations of specific brief models.

The next phase began during the 1992-93 year by adapting a model based upon the Colorado State system (Dworkin and Lyddon, 1991). The Colorado State model makes use of a set of criteria that provides an indication of who can best benefit from time limited treatment. Their referral criteria for determining short-term and intermediate treatment (5-10 sessions) use 9 variables called action markers which they tie to "acceptable" diagnostic categories for briefer work (i.e. Adjustment Disorders and V-Codes). RAther than focus on diagnoses as criteria, our staff decided to take the CSU action markers and see how they may be helpful in our intake decision process. Our agency used this first year of implementation to try out these adjustments. The 9 action markers were modified to become 6 variables that were descriptive of client characteristics and 4 variables that were therapist's assessment of client capability for using treatment. Later we added the recommendation section for the counselor to specify which of four categories of treatment short term (up to 5 sessions), intermediate (5 to 10 sessions), extended and/or group work would be appropriate. It also specifies other options including extended assessment (more than 1 intake session) and referral. These action markers became a checklist attached to the intake summary report (see our revised Intake Action Markers in Appendix).

Implementation soon pointed out several additional steps for improvement of the system. Staff were immediately needing to be better informed concerning referral sources if that option was to be appropriately utilized. A task force of staff spent several months making contact with agencies and private practitioners in the area creating an agency file of basic data on all referral sources. An even more important task was to determine how staff in actual practice identified and

made their assessments on the action markers. It was evident that there could be a big gap between the action marker statements as a formal checklist and the many informal ways that each staff determined whether or not to check the marker. In order to assess the counselors decision processes staff were asked to make statements about what they specifically looked for on each action marker. These statements were then put on 3X5 cards and sorted by each staff according to priority toward making a yes/no action marker decision. The results of the card sort analysis was concluded this past Spring and is summarized on a separate page. It is perhaps, the most unique contribution, that our experience can offer to other centers or agencies that might be attempting a similar system. (See attached samples of the card sort and the 1993-94 version of the Intake Action Markers.)

Finally, we realized that there is a need to have some consultative staff inputs on the initial decisions at both intake and at review times for extending service delivery. Originally, these decisions were made through several previously established methods such as supervision with interns, by staff case presentation during weekly case conferences or by individual supervision with the clinical coordinator. As an addition to these steps, a second set of action markers had been devised by staff to help alert ourselves to how we were making decisions of continued services when reviewing progress around the 10th session; the Case Review Worksheet was devised for staff to use but not made a mandatory part of the process. In addition, some staff feedback was provided through summary reports of individual case loads which described the number of clients seen by length of contact and client diagnostic characteristics. This provided some data, albeit quantitative, on how staff were able to implement the brief treatment model. In order to improve the effectiveness of staff consultation on intake decisions a new system will be implemented this Fall which is called the treatment decisions-team. It consists of a rotating number of staff and interns who meet twice weekly with the clinical coordinator to make intake decisions.

At this stage it is still apparent that the agency is only part way to attaining the goals of an effective brief treatment decisions system implemented from the beginning of client contact. The Director and staff have been guided by several principles during this process. (1) A system will only work effectively if all staff are knowledgeable, informed about the systems purpose, and willing to support the approach. (2) The system must have flexibility and adaptability to both individual client differences as well as staff variability. (3) Experience, even trial and error, is invaluable in defining how a plan can best translate into practice. (4) All facets of the service delivery process, from public information about the service to the forms used at intake, may support or deter the successful implementation of the system. (4) Finally, we know that the proof of any process is best determined by evaluating the results. After the system has been improved it will be important to do a thorough evaluation of outcomes including the validity of predictions made at intake. Only then will we know if our efforts are achieving the goals stated in our agency mission. Our most recent comparison of our 1990-91 contact data with our 1992-93 data shows that there has been a shift from: the 80% of clients seen for less than or equal to 7 sessions in 1990-91 to 81.5% in 1992-93; 10% seen for 8-16 sessions in 1990-91 to 13.3% in 1992-93; and the 10% seen for 17 or more sessions who received more than 40% of appointments, to 5.2% seen more than 17 sessions and receiving only 24.5% of appointments. Though we cannot at this time say there is a causal relationship between these intake changes and the above differences between these two years data, the 15.5% decrease is appointments devoted to long-term clients seems to suggest that we are headed in a helpful direction.

References

Dworkin, D.S. & Lyddon, W.J. (1991). *Managing demands on counseling services: The Colorado State University experience.* **Journal of Counseling and Development**, 69 (5), 402-407.

Gilbert, S. P. (1992). *Ethical issues in the treatment of severe psychopathology in University and College Counseling Centers.* **Journal of Counseling and Development**. 70 (6), 695-699.

DECISION CRITERIA DETERMINED BY COUNSELORS

TO ASSESS ACTION MARKERS

Medians and means of top 4 rated items as determined by 15 staff

Action Marker #1 Non-severity of prior treatment

Decision Criteria:	Median:	Mean:
1. No history of psychosis	2.00	2.54
2. Previous treatment acute or developmental	4.00	3.91
3. No psychiatric hospitalization or unsuccessful substance abuse treatment	4.00	4.09
4. Previous treatment did not entail "danger to others"	4.00	4.82

Action Marker #2 Positive use of prior therapy

1. Client able to articulate how prior treatment was helpful & evidenced in behavior	1.00	1.18
2. If previous therapy not helpful able to show insight as to what happened, their role in it, and what they would do differently	2.00	2.18
3. Current presenting issue less serious than previous therapy issue	3.00	3.18
4. Client able to differentiate between therapy and life	4.00	3.91

Action Marker #3 High motivation for change

1. Client appears committed to change	2.00	2.54
2. Client shows ego strength to make changes and tolerate feedback	2.00	2.54
3. Client desires a basic shift in perspective, understanding & behavior rather than just wanting to dump anger & frustration	3.00	3.27
4. Client shows enough pain to be motivated	4.00	4.09

Action Marker #4 Desire for symptomatic relief

1. Client shows that there are specific symptoms	1.00	2.09
2. Client is willing to do homework	3.00	3.35
3. Client shows willingness to talk	4.00	3.63
4. Client is able to relate to own behavior	4.00	3.81

Action Marker #5 Presence of a situational problem

1. Client presents issues around adjustment to a specific life situation or event	3.00	2.82
2. Client can identify stressor that motivated them to make an appointment	3.00	2.91
3. Identify problematic behaviors (i.e. non-productive stress reactions, procrastination)	3.00	3.00
4. Age appropriate issues such as separation and autonomy from parents, career indecision...	4.00	4.00

Action Marker #6 Ability to clearly identify a focal conflict or impasse

1. Client identifies problem specifics, questions and shows some problem solving capability	2.00	2.27
2. Client's presentation of issues has a manageable theme	2.00	3.27
3. Client does not engage in excessive externalizing or vagueness	4.00	4.54
4. Client shows ability to take responsibility for conflict when appropriate	4.00	5.00

Action Marker # 7 Ability to introspect, self monitor and experience feelings

1. Client shows appropriate affect connected with content as issues are presented	3.00	3.00
2. Client shows ability to recognize and reflect upon his or her feelings	3.00	3.28
3. Client shows ability to observe and analyze self	4.00	3.27
4. Client shows ability to hypothesize reasons and solutions for current issues	4.00	4.73

Action Marker #8 Ability to develop trust, be open and form relationship with therapist/others

1. Client able to appropriately interact with therapist in sessions	2.00	2.27
2. Client has history of positive interpersonal relationships	2.00	2.64
3. Client is able to talk about personal matters	3.00	3.36
4. History of positive use of support systems	4.00	4.00